

**ANNUAL HEALTH INFORMATION**  
2016-2017 School Year

**LUVERNE PUBLIC SCHOOLS**  
**RETURN TO SCHOOL**  
**HEALTH OFFICE**

NAME: \_\_\_\_\_

SEX: Male Female

BIRTH DATE: \_\_\_\_\_

GRADE ENTERING THIS YEAR: \_\_\_\_\_

**HEALTH CONCERNS:** Please check if your student is subject to the following conditions:

\_\_\_ VISION PROBLEMS: \_\_\_ Glasses Prescribed \_\_\_ Wears Glasses/Contacts Full Time \_\_\_ Classroom Only

\_\_\_ EAR/HEARING PROBLEMS (check all that apply) \_\_\_ Frequent ear infections \_\_\_ Hearing loss \_\_\_ Has ear tubes \_\_\_ Wears hearing aid

Check which ear(s) affected  
Right Left

\_\_\_ Date tubes inserted: \_\_\_\_\_

\_\_\_ ALLERGIES:(To what?) \_\_\_\_\_ \_\_\_ ASTHMA \_\_\_ DIABETES

\_\_\_ HEART DISEASE \_\_\_ SEIZURES \_\_\_ BLADDER /BOWEL PROBLEMS \_\_\_ MENTAL HEALTH ISSUES

COMMENTS: Explain items checked above and how school staff should handle any problems.

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** Please list the medications your student takes either daily or occasionally.

Medication Name	Purpose	Dosage	How often taken?
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\_\_\_\_\_  
\_\_\_\_\_

\*School District Policy states that any student taking prescription medication during the school day must have a written consent form signed by the parent/guardian and physician/licensed prescriber. The medication must be in the original pharmacy container. The consent forms may be obtained from the Health Office or [www.isd2184.net](http://www.isd2184.net).

**EMERGENCIES:** Does your student have a health problem, which could result in an emergency? \_\_\_Yes \_\_\_No

If yes, describe: \_\_\_\_\_

In case of emergency, if you cannot be reached, who shall be called?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICATION CONSENT:**

The Luverne Schools has acetaminophen (generic Tylenol) and ibuprofen (generic Advil) available for students with complaints of headache and/or muscle aches. Written parent/guardian permission must be on file for students to receive acetaminophen or ibuprofen at school, by signing this form the parent/guardian gives consent for acetaminophen or ibuprofen to be given by the school nurse or her designee.

Signature of parent/guardian \_\_\_\_\_ Daytime Phone # \_\_\_\_\_ Date \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. If this form is not completed it may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. School Nurse - Phillip Paquette, RN